Section V

Preparation and Use of Other Inpatient Treatment Record Forms

8-17. DD 539

a. DD 539 is used for cases of a minor nature that require no more than 48 hours' hospitalization. For example, it is used for lacerations, plaster casts, removal of superficial growths, and accident cases held for observation. DD 539 will not be used for death cases, admission by transfer, probable medical-board cases, and cases involving serious medical incidents.

b. DD 539 may also be used when military members are hospitalized for uncomplicated conditions not normally requiring hospitalization in the civilian sector, for example, measles or upper respiratory infection. If the case becomes complicated, paragraph d below applies.

c. DD 539 may be used for cases in which general anesthesia was given only if--

(1) The patient is classified as American Society of Anesthesiologists Class I or II; that is, the patient has no organic, physiologic, biochemical, or psychiatric disturbance, or the systemic disturbance is well controlled, or the pathologic process to be operated on is localized and does not entail a systemic disturbance.

(2) The patient will be hospitalized no more than 48 hours. When DD 539 is used for these cases, the physical examination section must fully describe the cardiopulmonary findings. (Terms such as "normal," "wnl," and "negative" will not be used.) It must also describe any exceptions or other pertinent findings.

d. When DD 539 is used, SF 502 may be replaced by a final progress note (SF 509). However, when a short stay becomes a long one, SF 502 must be prepared. In such cases, SF 504, SF 505, and SF 506 need not be completed in addition to DD 539; the reasons for the extended stay will be fully recorded in the progress notes (SF 509). Conversely, when a long stay is expected but the patient is discharged within 48 hours, DD 539 will not be prepared in addition to the already completed SF 504, SF 505, and SF 506, and the case may be summarized in the progress notes (SF 509) instead of in SF 502.

8-17.1. DD Form 792

DD Form 792 (Twenty-Four Hour Patient Intake and Output Worksheet) is a worksheet used to record all fluid intake and output. It is completed by nursing personnel. After the totals have been recorded on the graphic records (SF 511 or DD 539), the worksheets should be destroyed. The worksheet should not be filed in the ITR.

8-17.2. DA Form 3950

DA Form 3950 (Flowsheet For Vital Signs and Other Parameters) is a worksheet or a flowsheet to record temperature, pulse, blood pressure, and respiration or the columns may be labeled as needed. Vital signs for a group of patients can be recorded and subsequently transcribed to the graphic record (SF 511 or SF 537) of the individual patient. The worksheet may be destroyed after the readings have been transcribed to the individual patient's graphic record. When used as a flowsheet to record frequent vital signs or other parameters for an individual patient, the DA Form 3950 will be filed in the patient's ITR.

8-18. Laboratory forms

a. Laboratory forms (SF 545, SF 546, SF 547, SF 548, SF 549, SF 550, SF 551, SF 552, SF 553, SF 554, SF 555, SF 556, and SF 557) and automated versions of them are used to request laboratory tests and to report the results of those tests. When a computerized or automated summary of all previous laboratory tests is provided, only the cumulative final report should be filed in the record. Health care practitioners should refrain from making notations on the lab slips; such notes belong in the progress notes. The forms are three-part sets (original and two copies). When a test is requested, the whole set is sent to the laboratory. After the results are recorded, the third copy is kept in the laboratory files. The original is routed for immediate filing in the ITR or OTR or outpatient HREC. The second copy is routed to the requesting practitioner for use and disposition.

b. Carbon copies of laboratory reports will not be filed in the medical record. The MTF commander will ensure that each patient's laboratory test reports are prepared correctly.

c. General instructions for preparing these forms are given in table 8-1. Instructions for each form are given in table 8-2.

8-19. DA Form 4256

a. Use of DA Form 4256. DA Form 4256 is a three-copy, carbonless form. The original copy (white) remains with the patient's permanent record. The second copy (pink) is sent to the pharmacy, where it is kept until the patient is discharged. (The pharmacy must receive a copy of all orders to ensure appropriate surveillance of food-drug and laboratory-drug interactions.) The ward copy (yellow) may be used as a medication or treatment reminder and will be discarded when no longer needed. Instructions for completing DA Form 4256 are provided in b through g below.

b. Preparation. All entries will be made with ballpoint pen using blue-black or black ink, or will be computer entries. Entries must be legible on all three copies. In each Patient Identification section, addressograph plates should be used. (See paras 3-5b and 3-6.) The Nursing Unit, Room Number, and Bed Number blocks should also be completed.

c. Method of writing orders. More than one order may be written in each section of DA Form 4256, but no more than one order may be written on a single line. The prescriber will record the date and time that each order is written. Each order must be accounted for separately; use of the entry "routine orders" (to imply a number of predetermined orders) is prohibited. However, a group of orders written at the same time for a patient needs only one signature. Standard orders overprinted on DA Form 4256 also must be signed by the prescriber.

d. Method of accounting for orders. Actions taken to comply with written orders will be noted in the far right column of DA Form 4256, the "List Time Order Noted and Sign" column.

(1) The clerk or nurse who notes two or more orders may enclose the orders in brackets, list the time orders are noted, and sign or initial his or her name. All STAT orders, however, must be individually accounted for with the time the order is noted and the signature or initials of the clerk or nurse. This entry implies that proper action has been taken or the order, as written, has been transcribed on DA Form 4677 or DA Form 4678.

(2) Single action orders need not be transcribed to the DA Form 4677 or DA Form 4678 if the order is noted by the RN. A single action order is a one-time order that is completed within the verifying nurse's tour of duty. It should require no further nursing activity once signed off including, if indicated, documentation of the efficacy of the intervention. In the right hand column of the form, the RN will write "Done" with his or her signature and the date and time that the order was completed. Each single action order must be accounted for individually; brackets will not be used to sign off a group of single action or "STAT" orders. If the single action is not completed within the responsible RN's tour of duty, the order must be transcribed to the DA Form 4677 or DA Form 4678.

e. Method of discontinuing orders. To discontinue a medication or treatment, the prescriber must write and sign the stop order. (Automatic stop orders (for example, for antibiotic or controlled drugs) will be governed by written local policy.) When an order is stopped, it must be accounted for (d above) and then noted on DA Form 4677 or DA Form 4678 by putting "DC (discontinued)/date/initials" and drawing a single line through the HR (hour) and Date Completed/Dispensed blocks beside the stopped order. Corresponding annotations in an automated system such as CHCS are acceptable.

f. Verbal orders. Verbal orders will be used only for emergency STAT orders. The registered nurse who accepts the order must write it on DA Form 4256 and enter after it "Verbal order (doctor's/nurse's name, grade, Army nurse corps or registered nurse)." The prescriber must countersign the order as soon as possible, but no later than 24 hours after the emergency.

g. Telephone orders. Telephone orders will be held to the minimum and accepted only by an RN; they must be countersigned by the prescriber within 24 hours. The RN

accepting the order(s) must record the order(s) on the DA Form 4256 followed by the notation "Telephone Order(s)"; the physician's name; and the RN's name, rank, and title.

8-19.1. DA Form 4677

a. Purpose. DA Form 4677 (Clinical Record--Therapeutic Documentation Care Plan (Non-Medication), printed on colored paper, is used for non-medication doctors' and nurses' orders and to document the patient's acuity category. Medical orders will be transcribed from DA Form 4256. Nursing orders will be indicated by writing "NIO" for nursing initiated order and the RN's initials are noted in the Initials column. Nursing orders may relate to identified nursing problems and/or nursing diagnoses, or reflect established standards of care. Nursing orders that reflect standards of care may be written without a corresponding problem. Overprints of orders may be printed on the form per appropriate local or command policy.

b. Preparation. Enter all patient identification data as indicated on the form.

c. Content.

(1) Allergies. Specify the presence or absence of allergies. When known, indicate the specific allergen.

(2) Primary medical diagnosis. Enter the current diagnosis. Add other diagnoses if they significantly affect care to be given.

(3) Recurring actions.

(a) Order date. Enter the date that the current order was written.

(b) Initialing. The clerk or nurse who transcribes an order must initial the appropriate block on the form. If a ward clerk or a licensed practical nurse transcribes the order, an RN must initial in the lower portion of the box. The RN's initials indicate that the RN verified the transcribed order with the original order on DA Form 4256 and is, therefore, accountable for its accurate transcription and its appropriateness from a nursing standpoint.

(c) Recurring actions, frequency, time. This section is used for actions that are scheduled and repetitive. The complete order, as originally written, must be transcribed to this section.

1 Hour. Specific times for the order to be accomplished are listed vertically. Each space is for a separate time of action. Orders that are in effect throughout the shift and are not time-related (for example, seizure precautions, intake and output) are indicated by designating the inclusive times for each shift; for example, 07-15, 15-23, 23-07. The abbreviations D, E, and N will not be used.

2 Date. The top row of spaces is used to indicate the date the action is accomplished.

3 Initialing. The person responsible for carrying out the order or for verifying compliance will initial the block opposite the specific hour for action and under the appropriate date column.

4 Use of DA Form 4677 to document patient acuity. The WMSN acuity category is documented on this form. An entry should be made in the Recurring Actions/Frequency/Time column: "WMSN Category." Two lines are used. The patient's WMSN acuity category is recorded on the first line under the appropriate date, and the initials of the RN who determined the acuity category are recorded in the block directly beneath the category.

5 Use of DA Form 4677 as a flowsheet. To reduce the writing of nursing notes, DA Form 4677 may be used to document patient information requiring frequent recording and/or the patients' response to medical orders and nursing interventions. All assessment or measurement components must be specified in the order written on DA Form 4677, for example, check pedal pulses and right leg circumference every 4 hours. The findings related to this assessment are likewise recorded on DA Form 4677. A local policy is required to explain this method of documentation and for coding the patient's response to care. For example, initials only indicate that the order has been completed; initials and "+" indicate that the nursing intervention and/or patient response was satisfactory and/or within normal limits; initials and "O" indicate the results of the nursing intervention and/or patient response were unsatisfactory, not observed or omitted. All negative or unexpected responses or unfavorable patient outcomes require documentation in nursing notes. Any codes used must be defined on the DA Form 4677.

6 Discontinued order. When a multiple line order is discontinued, a diagonal line is drawn across the unused blocks. If it is a single line order, draw a horizontal line; write "DC/date/time/initials" above either of the lines. For quick, visual recognition of a discontinued order, a yellow highlighter or accent pen which will not penetrate the paper or obliterate the writing may be used to line over the order and the associated blocks.

d. Single Actions. If a single action order is not completed within the responsible RN's tour of duty, the order becomes a delayed order and is transcribed to the Single Actions column.

(1) Order Date. Same as in c(3)(a) above.

(2) Initialing. Same as in b(3)(b) above.

(3) Single Actions. The complete order, as originally written, must be transcribed to this column.

(4) Date and Time to Be Done. If known, enter the date and time the action is to be taken. Indicate "on call" if so ordered.

(5) Completed order. The Date/Time/Initial blocks show that the order was accomplished. If the order was not completed, do not initial. Place a circle(s) in the Date/Time/Initial block(s) and explain in the nursing notes.

e. Pro re nata (PRN) actions. Use this when the time of an order is not predictable. Leave sufficient space on the DA Form 4677 to accommodate the expected frequency of the PRN action and the patient's response per local policy and the direction provided in c(3)(c)5 above.

(1) Order/Expir (expiration) Date. Enter the date the current order is written in the top portion. If applicable, enter the expiration date in the bottom portion.

(2) Initialing. Same as in c(3)(b) above.

(3) PRN Action, Frequency. Indicate the action to be taken and its frequency.

(4) Time/Date/Completed. Each block indicates a separate action. The person completing the action enters the date, time, and initials at the time of completion.

f. Recopied orders.

(1) When space in the Date Completed column is filled, a double line is drawn across the entire page just below the last entry. Directly below the double line, or on a blank DA Form 4677, write "Recopied Orders." The upcoming dates are filled in, for each order still in effect, and the date of the original order is recopied. The individual copying the order, if other than an RN, and the verifying RN will follow the initialing procedures as previously described in c(3)(b) above. If the RN recopies the orders, the only required authentication will be the nurse's signature at the end of the recopied orders.

(2) In the event that orders need to be recopied before the Date Completed columns are filled, the order is indicated as recopied by a diagonal or single line drawn across the remaining blocks. Recopied/date/initials are noted above the line. Existing initials are bracketed to indicate no further use of the remaining blocks.

8-19.2. DA Form 4678

a. Purpose. DA Form 4678 (Clinical Record--Therapeutic Documentation Care Plan (Medications)), printed on white paper, is for medication orders and accompanying nursing orders which pertain to the administration of the ordered medication. Medication orders will be transcribed from DA Form 4256. Nursing orders pertinent to medication administration, initiated by the RN, and written on this form, will be indicated by placing

NIO/nurse's initials in the Verify By Initialing column. Overprints of physician or nurse orders may be printed on the form per appropriate command or local policy.

b. Preparation. Enter all patient identification data as indicated on the form.

c. Content.

(1) Allergies. Specify the presence or absence of allergies. When known, indicate specific allergen.

(2) Primary diagnosis. Enter current diagnosis. Add other diagnoses if they significantly affect care to be given.

(3) Recurring medications.

(a) Order date. Enter the date of the current order.

(b) Initialing. The clerk or nurse who transcribes an order must initial the appropriate block on the form. If a ward clerk or a licensed practical nurse transcribes the order, an RN must initial in the lower portion of the box. The RN's initials indicate that the RN verified the transcribed order with the original order on DA Form 4256 and is, therefore, accountable for its accurate transcription and its appropriateness from a nursing standpoint.

(c) Recurring Medications, Dose, Frequency. This column is used for recurring drug administration, including controlled substances, or actions when compliance with the order is repetitive and scheduled. The complete order, as originally written, must be transcribed to this section.

(d) Hour. Specific times for the order to be accomplished are listed vertically. Each space is for a separate time of administration. Orders that are pervasive throughout the shift and are not time-related (for example, intravenous (IV) rates, oxygen administration) are indicated by designating the inclusive times for each shift; for example, 07-15, 15-23, and 23-07. The abbreviations D, E, and N will not be used.

(e) Date. The top row of spaces is used to indicate the date the action is accomplished or medication is administered.

(f) Initialing. The nurse will initial the block opposite the specified time for administration and under the appropriate date column. The patient's response to the medication may also be indicated. When placed in the designated block, the nurse's initials indicate that the medication has been administered. The nurse's initials with the letter "(E)" indicate that the administered medication was effective and achieved the desired results (for example, meperidine given for pain relieved the pain). The nurse's initials with "(I)" indicate that the administered medication was ineffective. This notation

requires a nursing note to describe the patient's status and the actions taken to address the patient's condition.

(g) Discontinued order. When a multiple line order is discontinued, a diagonal line is drawn across the unused blocks. If it is a single order draw a horizontal line; write "DC/date/time/initials" above either of the lines. For quick, visual recognition of a discontinued order, a yellow highlighter or accent pen, which will not penetrate the paper or obliterate the writing, may be used to line over the order and the associated blocks.

d. Single order action, pre-operatives. A single action medication order which is not completed within the verifying RN's tour of duty becomes a delayed order and is transcribed to the single order, pre-operatives column.

(1) Order date. Self-explanatory.

(2) Initialing. Same as in c(3)(b) above.

(3) Single Order, Pre-operative. The complete order, as originally written, must be transcribed to this column.

(4) Date/Time To Be Given. If known, enter the date and time the drug is to be administered. Note "on call" if so ordered.

(5) Completed order. The nurse who administers the medication enters the date, time, and his or her initials. Do not initial an order that is not implemented. Place a circle(s) in the Date/Time/Initials block(s) and specify the reason in the nursing notes.

e. PRN medications. Use when the time of administration is not predictable.

(1) Order/Expir Date. Enter the date the current order is written in the top portion. If applicable, enter the expiration date in the bottom portion.

(2) Initialing. Same as c(3)(b) above.

(3) PRN Medication, Dose, Frequency. Indicate the medication to be administered, dose, route, frequency, and reason for the medication (for example, meperidine 50 mg, IM q.4H prn, pain). The patient response may be documented as described in c(3)(f) above in the nursing notes.

(4) Time/Date Dispensed. Each block indicates a separate action. The person administering the medication enters the time, date, and initials at the time of completion.

f. Recopied orders.

(1) When space in the Date Dispensed column is filled, a double line is drawn across the entire page just below the last entry. Directly below the double line, or on a blank DA Form 4678, write "Recopied Orders". The upcoming dates are filled in for each order still in effect and the date the original order is recopied. The individual copying the order, if other than an RN and the verifying RN will follow the initialing procedures as previously described in c(3)(b) above. If the RN recopies the orders, the only required authentication will be the nurse's signature at the end of the recopied orders.

g. DA Form 4028 (Prescribed Medication). When unit dose is not provided, DA Form 4028 will be prepared whenever a medication is prescribed. The purpose is to ensure that patients receive medications of the kind and quantity prescribed for them. The card will be destroyed upon change of orders. This card is not used when unit dose pharmacy support is provided.

8-19.3. DA Form 4107

a. General. The medical or dental officer responsible for the patient's operation or special treatment will initiate and complete section A, DA Form 4l07 (Operation Request and Worksheet), except for items 20 and 21. Section B will be completed by the anesthesiologist or nurse anesthetist providing care for the patient. Where no anesthesia representative is assigned or present, the nursing team circulator will complete section B, DA Form 7001 (Operating Room Schedule) and DA Form 4108 (Register of Operations) based on accuracy and completeness of DA Form 4107.

b. Purpose. This form is intended for concurrent and sequential use to schedule and record all surgical procedures performed in the main ORs and ambulatory surgery center. When anesthesia and/or OR nursing personnel are required to attend or monitor patients, DA Form 4107 will be used (for example, labor and delivery, special procedures x-ray clinic, cardiac catheterization).

c. Detailed instructions.

(1) Section A--Request for Surgery.

(a) Items 1 through 14. Self-explanatory.

(b) Item 15. If purulent material or infectious conditions are present or anticipated, write "yes."

(c) Item 16. Self-explanatory.

(d) Item 17. Self-explanatory.

(e) Item 18. Self-explanatory.

(f) Item 19. Note special instructions, to include special solutions for prepping.

(g) Item 20. Chief, operating room nursing section or designee will note name(s) of scrub person(s) followed by name(s) of circulator(s).

(h) Item 21. The chief of anesthesia and operative service or designee will complete.

(i) Item 22. Indicate type of anesthesia desired (for example, general, regional, local, or topical).

(j) Item 23. Indicate special instruments and/or equipment other than routine (for example, power equipment, tray, tourniquet, etc.). In addition, indicate patient limitations (for example, deaf, mute, language barrier), which will assist operating room staff in planning patient care.

(k) Item 24. Self-explanatory.

(2) Section B--Operation Worksheet.

(a) Items 25 and 26. Self-explanatory.

(b) Item 27. Septic is defined by using classification of the operative wound, and applying the National Research Council criteria: Clean wounds, clean-contaminated wounds, contaminated wounds, and dirty-infected wounds.

(c) Items 28-32. Self-explanatory.

(d) Item 33. Anesthesia Time: "Time Began" is defined as the beginning of patient preparation after the patient has arrived in the holding area of the surgical suite or satellite facility. This time commences with chart review and placement of IV lines, invasive monitors, and/or noninvasive procedures by anesthesia personnel. "Time Ended" means actual clock time at which the anesthesia provider leaves the patient in the post anesthesia recovery unit, intensive care unit, or other post surgical unit.

(e) Items 34-38. Enter agents and techniques. If none, indicate by lining out the appropriate space(s).

(f) Item 39. Note adjunctive procedures not intrinsically a part of delivery or routine anesthesia such as hypothermia, anesthesia by tracheostomy, central venous pressure monitoring, Swan-Ganz monitoring, transvenous pacemakers, and arterial lines.

(g) Item 40. "Time Began" means the actual clock time the nursing team began preparation in the room assigned for the case. "Time Ended" means actual clock time the cleaning of the room is completed and ready to receive the next patient. Note, these times will not be the same as anesthesia or operation times.

(h) Items 41-44. Self-explanatory.

(i) Item 45. Note number(s) and type(s) of drain(s).

(j) Item 46. Indicate "None," "Correct," or "Incorrect." Enter the last name of the professional nurse who performed and verified the sponge count.

(k) Item 47. Identify the specimen or tissue and state the time and date it was sent to pathology or what disposition was made of the specimen or tissue.

(l) Item 48. Self-explanatory.

(m) Item 49. Indicate the total episodes of surgery by using the following definitions.

1 Episode of OR Nursing. An episode of OR nursing is based on a combination of two factors: OR personnel and time. One episode of OR nursing is assigned for the initial 3 hours or fraction thereof, for one nursing team. An OR nursing team consists of one scrub person and one circulator person. OR nursing personnel are permanently assigned to the OR. Each additional OR nursing person for a particular case equals 0.5 episode.

2 Episode of Anesthesia. An episode of anesthesia is also based on a combination of two factors: anesthesia personnel and time. One episode of anesthesia is counted for the initial 3 hours or fraction thereof for one anesthesia provider. Any fraction over the initial 3-hour period is an additional episode. One episode is also added for each additional anesthesia provider fully assigned to the case.

3 Method of Calculation: The following case scenarios provide examples for calculation of episodes of OR nursing and episodes of anesthesia (fig 8-2).

(n) Item 50. Enter any complications that occurred in the OR or those unusual situations in the preoperative period that relate to the anesthesia or surgical experience.

(o) Item 51. When a dictation capability exists, physicians will sign their names after completion of dictation.

(p) Recorded in Register. After the case has been recorded on the DA Form 4108 or entered into the automated data processing system, the person initiating this task will show completion by initialing.

c. Disposition. The form consists of four copies. Upon completion of section B, DA Form 4107 is separated. Retain the original copy in the OR section until the information is transcribed to DA Form 4108 and SF 516. Distribution of additional copies will be

determined by the chief, anesthesiology and operative service. All copies may be destroyed when no longer needed.

8-19.4. DA Form 7001

a. General. DA Form 7001 (Operating Room Schedule) is prepared daily for the next day reflecting all scheduled operative and anesthesia procedures, additional procedures, such as emergencies, and for changes to the OR schedule. Incorporating elements from section A of DA Form 4107, prepare DA Form 7001 either on the cutsheet version or on offset masters for printing of duplicate copies.

b. Preparation and distribution. Entries may be typed or handwritten, if they are legible. Additionally, DA Form 7001 can be prepared electronically and may be duplicated for distribution. It serves as a central communication tool concerning surgery. DA Form 7001 covers a 24-hour period beginning at 0000 and ending at 2400. Cases beginning on 1 day and ending on the next day should be posted on the beginning day's schedule (that is, started the case at 2300, 24 Sep 91 and ended at 0200, 25 Sep 91. The case should be recorded on the schedule for 24 Sep 91).

c. Use. The original DA Form 7001 can be used to verify data recorded on DA Form 4107 prior to entry onto DA Form 4108. Duplicated DA Form 7001 can be used for patient transport identification slips, individual operating room case slips, Centralized materiel service instrumentation verification, quality assurance tracking and trending, pre- and postoperative statistical data, anesthesia interview assignments, progression of operative schedule, completion and/or cancellation of cases, mass casualty exercises, staffing of personnel, and any other pertinent patient information (for example, biohazard, special care needs for transport).

d. Detailed instructions.

(1) Item 1. Enter the name of the MTF.

(2) Item 2. Self-explanatory.

(3) Item 3. Enter the time the case is scheduled to begin and in what specific (number) OR; for example, 0730, OR #1.

(4) Item 4. Enter the patient's full name, identification category, age, and religion; for example, Williams, John D., AD, 18, P.

(5) Item 5. Self-explanatory.

(6) Item 6. Enter ward from which the patient is sent to surgery and the ward or specialty care unit to which the patient will go after surgery (for example, from 64 to RR).

(7) Item 7. Enter the proposed surgery as recorded on DA Form 4107, item 9 (for example, exploratory laparotomy, possible bowel resection).

(8) Item 8. Enter the names of all operating surgeons with the primary surgeon first (for example, Dr. White and Dr. Smith).

(9) Item 9. Enter the name and status of the OR nursing personnel scrubbing and circulating. Indicate scrub with (S) and circulator with (C) (for example, SGT Tamp (S) and CPT Rowe (C)).

(10) Item 10. Enter the names of all the anesthesia providers to include physician staff personnel (for example, Major Down, MC or Dr. Jones).

(11) Item 11. Enter the anesthetic as indicated on DA Form 4107, item 22. Enter blood and associated products as indicated on DA Form 4107, item 14 (for example, General/WB 2000 cc FFP 1500 cc).

e. Disposition. Destroy upon completion of entry of data onto DA Form 4108, or when no longer needed as deemed by local policy.

8-19.5. DD Form 1924

DD Form 1924 (Surgical Checklist) will be placed on the front of each patient's chart prior to surgery. It provides a visual check of the medical forms and procedures required prior to arrival in the operating suite. The DD Form 1924 is designed to permit use of the addressograph to complete the patient's identification. The inpatient identification plate will be placed in the envelope provided on the form and will remain with the DD Form 1924 until the patient returns to his or her ward. Nursing personnel will place their initials in the proper columns as each preoperative check and procedure is completed. The RN releasing the patient to the OR staff members will sign this form at the time of release. The form will be destroyed when no longer required.

8-19.6. DA Form 4108

a. General. DA Form 4108 (Register of Operations) is a record of all surgical procedures performed. Normally, it will be kept and maintained in the OR suite. Where surgical procedures or anesthesia monitoring is undertaken outside the OR suite (for example, obstetrical suite, urology, cardiology, plastic, dental clinic, etc.), an individual DA Form 4108 will be maintained by the respective department, service, or clinic. Information from the completed DA Form 4107 will be transposed to DA Form 4108. Accuracy and completeness of the register is imperative since this document may be used for statistical computations, research, feeder reports to higher headquarters, and hospital accreditation, as well as support for staffing and space requirements.

b. Availability. Covers for the chronological collection of each year's DA Forms 4108 are available through supply channels.

c. Arrangement. Arrange pages chronologically with monthly recapitulation of total procedures. Sequence number 1 is the first procedure begun from 0001 on the first day of the month. The final sequence number for the month is the last procedure begun before 2400 on the last day of that month. Pages will be numbered in the space provided in the upper right corner. Both sides will be used. At the end of each month, tally figures may be entered in the margin, and the cumulative total carried to the upper left corner of a new page to begin a new month's record. Suitable tabs may be affixed to identify the month.

d. Recording of data. Entries may be typed or handwritten if they are legible. Entries are adaptable for computer input.

e. Corrections of errors. Erasures are prohibited. A line will be drawn through an incorrect entry. Initials of the person making the entry will be placed above the lined portion. Correct information will be recorded following the lined entry.

f. Detailed instructions. See paragraph 8-19.4b for entry assistance.

(1) Hospital. Enter the name and location.

(2) OR number. Enter #1, #2, #3, etc.

(3) Emergency. Indicate with an "X" if an emergency procedure is used.

(4) Case number. Sequence within the particular OR number noted in (2) above.

(5) Surgeon(s). The surgeon is listed first, followed by assistants in descending order.

(6) Combat. Use currently acceptable medical letter combination or abbreviation to indicate the source of injury if the result of hostile fire.

(7) Nursing time. Indicate time "Began" and time "Ended" from DA Form 4107.

(8) Counts. Indicate after each (for example, sponge, needle or sharp, instrument) "C" for correct, or "IC" for incorrect.

g. Disposition. These binders will be disposed of under AR 25-400-2. Maintain at least from one Joint Commission on Accreditation of Healthcare Organizations visit to the next, and for the time required by statutes of limitations. Additionally, maintain as deemed by local policy.

8-19.7. DA Form 5179

a. General. DA Form 5179 (Medical Record--Preoperative/ Postoperative Nursing Document) consists of a nursing assessment and generalized care plan for patients undergoing an operative procedure, and a postoperative evaluation. This form is to be prepared by an RN and will be a permanent part of the patient's clinical record. Data collection and review of the care plan is to be accomplished with the patient prior to the operative procedure. If unable to obtain data; for example, emergency surgery, document this in item 5. Item 11 is to be completed within 24 hours of the procedure.

b. Purpose. This form provides a record of the continuation of the nursing process from the time the patient leaves the ward or unit to go to the OR until the patient returns to a receiving unit.

c. Detailed instructions.

(1) Items 1-4. Self-explanatory.

(2) Item 5. Provides space for additional information such as family requests, information not identified in items 6 to 8 of the form.

(3) Item 6. Lists potential problems and/or needs of the patient. If the stated problem is relevant to the patient, an "X" should be placed in the area provided at the beginning of each statement and the problem statement completed by filling in each blank. A space is provided to write additional problems and/or needs.

(4) Item 7. States expected goals and outcomes. A space is provided to write additional goals and outcomes, if necessary.

(5) Item 8. Lists OR nursing interventions. The interventions not applicable to the patient are to be lined out and initialed. Space is provided for documenting additional interventions.

(6) Item 9. Self-explanatory.

(7) Item 10. Signature of RN completing Item 8.

(8) Item 11. Must be completed within 24 hours after completion of the operative procedure. Each patient problem and/or need identified in Item 6 must be evaluated here.

(9) Items 12-13. Self-explanatory.

8-19-8. DA Form 5179-1

a. General. DA Form 5179-1 (Medical Record--Intraoperative Document) documents the care of each patient undergoing an operative procedure. The form is to be initiated

prior to the operative procedure and completed after the operation. The form is to be prepared by an RN and will be filed on the right side of the ITR (DA Form 3444-series).

b. Detailed instructions.

(1) Item 1. Record how the patient arrived; that is, via litter, wheelchair, or bed; and by whom transported.

(2) Item 2. Verify, by RN, with payroll signature with rank and corps or civilian grade; for example, Mary S. Smith, CPT, AN or Betty T. Jones, RN, GS-10.

(3) Item 3. Specify day, month, year; use the military time the patient entered the main operating suite door.

(4) Item 4. Record the time the patient enters the OR and specify OR number plus case number for that room; for example, OR #l case 1.

(5) Item 5. Check descriptive word that best describes patient's preoperative status and any other appropriate comments.

(6) Item 6. Record names and titles of assigned personnel (permanent staff) and others such as student personnel, relief (meals, changes of shift) personnel.

(7) Item 7. Specify intraoperative position of the patient; record any other position(s); for example, split leg, and all positional devices or aids under comments. Draw or annotate any device or aid and its placement in Item 9.

(8) Item 8. Indicate the hair removal method in the appropriate box with "X" if hair removal is done by OR personnel; record the name of the individual performing procedure. Record type of site preparation solution and its strength (for example, 1%, 2%); site of preparation, and who performed preparation. Insert any appropriate comments such as skin conditions or reactions, for either task.

(9) Item 9. Record placement of indicated items by appropriate legend. Record other external devices such as blood pressure cuff, electrocardiogram electrodes or any other devices that are required by local facility policy or standing operating procedure.

(10) Item 10. Check YES (done) or NO (not done) for each count listed. Record each count as correct "C" or incorrect "IC": if incorrect make an explanatory entry in section 19. If "Other" is YES, add type of count and body space or cavity; for example, urinary bladder. Scrub and/or circulating personnel doing the count(s) should be identified by name.

(11) Item 11. Self-explanatory.

(12) Item 12. Record if electrosurgical unit (ESU) was used by "X" in the YES or NO block. Enter medical maintenance control number for every ESU and bipolar unit

used and any other information required by local facility policy (for example, manufacturer and model number). Record grounding pad(s) used (brand and lot number) and any other information required; that is, name of individual applying or removing pad.

(13) Item 13. List prosthesis or implant (for example, bone, screws, plates, vascular grafts, hulka clips, etc.) with manufacturer and identification numbers (lot number, quality control number) if available; attach sticker labels from implants if available.

(14) Item 14. Record any medications that the patient receives in the operating room not given by anesthesia personnel. Note wound irrigations as follows: NSS = normal saline solution; BSS = balanced salt solution; method of irrigation (for example, pulse, asepto, lavage), and when indicated; for example, for pediatric patients, note amount. Medications and orders are to be signed by the physician as the same verbal orders on DA Form 4256. Other orders or treatments are those performed during the operative procedures; for example, catheterization.

(15) Item 15. Record x rays and sites as indicated; specify special techniques (for example, fluroscopy), and/or equipment, (for example, C arm).

(16) Item 16. Enter "X" in the YES or NO blocks for specimens sent to the laboratory. Identify in NAME spaces the specimens sent to the laboratory by type and source or tissue; use FS for frozen section and C for culture. Examples: FS, nodule left vocal cord; C, anaerobic, gallbladder. If there are more than 11 specimens, record them in item 19.

(17) Item 17. Identify tubes, drains, and packings used by type, size, and site; for example, "vaseline gauze, 1/4 inch, L nostril."

(18) Item 18. Record any immobilizers used, type(s) of dressing applied and location(s). Examples: Posterior splint cast, Telfa, xeroform, dry sponge, etc., also see item 17.

(19) Use this section for further documentation or for reporting additional information on other items.

(20) Item 20, 21. Self-explanatory.

(21) Item 22. Signed by the RN with payroll signature with rank and corps or civilian grade.

c. This form is adaptable for computer inputs.

8-20. Radiologic forms (SF 519, SF 519A, and SF 519-B)

a. SF 519, SF 519A, and SF 519-B will be used to request radiologic examinations and to report the results. The forms are three-part sets (original and two copies). When an examination is requested, the whole set is sent to the radiology department. After the results are recorded, the third copy is kept in the radiology department files. (For disposition instructions, see AR 25-400-2, file number 40-66y, photograph and duplicate medical files and table 2-1 of this regulation.) The original is routed for immediate filing in the ITR, OTR, or HREC. The second copy is routed to the requesting practitioner for use and disposition. Carbon copies of radiologic reports will not be filed in the medical record.

b. Whether a typewritten, automated, handwritten, or verbal report, the results of all "wet" readings must be documented in the patient's medical record. This documentation can be found on either SF 519, SF 519A, SF 519-B, SF 600, or SF 558.

8-21. DA Form 5009-R

DA Form 5009-R (Medical Record--Release Against Medical Advice) will be used when the patient leaves the MTF against the advice of hospital authorities and attending practitioners. A parent or legal guardian will complete the "statement of representative" portion of the form if the patient is a minor or mentally incompetent. (DA Form 5009-R will be locally reproduced on 8 1/2- by 11-inch paper. A copy for local reproduction is located at the back of this regulation.)

Table 8-1
General instructions for preparing laboratory forms

Block: Patient Identification.
Completed by: Clinic or ward.
Instructions: Enter patient's name, register number and FMP or SSN of inpatient (only FMP or SSN of outpatient), treating MTF, ward or clinic, and date test is requested.
Remarks: Enter this information correctly. If possible, enter it by mechanical imprinting, using the ward plate or patient's recording card. If not, use ballpoint pen or typewriter.

Block: Urgency.
Completed by: Clinic or ward.
Instructions: Check the proper box.
Remarks: This block is not on SF 553 or SF 554.

Block: Specimen/Lab. Rpt. No.
Completed by: Laboratory.
Instructions: Enter the specimen or laboratory report number.
Remarks: This entry may be used to identify and monitor the request form in the laboratory.

Block: Patient Status.
Completed by: Clinic or ward.
Instructions: Check the proper box.
Remarks: "NP" and "DOM" are not used by the Army.

Block: Specimen Source.
Completed by: Clinic or ward.
Instructions: Check the proper box or write in the needed information.
Remarks: Some forms request other specimen information:
a. On SF 548, given specimen interval information.
b. On SF 553 and SF 554, given infection information. Extra information is needed on these forms to identify sensitivities and infecting organisms. Enter this information in the Clinical Information and Antibacterial Therapy blocks.
c. On SF 556, give specimen source information for obstetric patients.

Block: Requesting Physician's Signature.
Completed by: Clinic or ward.
Instructions: Enter clearly the name of the practitioner ordering the test. If he or she is a military member, enter grade and corps.
Remarks: The signature is not needed.

Block: Reported by.
Completed by: Laboratory.
Instructions: The technologist signs here after the test results have been verified.

Remarks: The chief of the laboratory ensures that test results are accurate.

Block: Date.
Completed by: Laboratory.
Instructions: Enter date that the report is completed by the laboratory.
Remarks: N/A

Block: Lab. ID No.
Completed by: Laboratory.
Instructions: Enter laboratory identification number.
Remarks: Like the Specimen/Lab. Rpt. No. block, this entry may be used to identify and monitor the request form.

Block: Remarks.
Completed by: Laboratory.
Instructions: Enter any special information for the practitioner or the patient's records.
Remarks: N/A

Block: Specimen Taken.
Completed by: Laboratory, Clinic or ward.
Instructions: Enter date and time the specimen is taken.
Remarks: This block is completed by whoever takes the specimen, either laboratory or ward or clinic personnel.

Block: Tests Requested.
Completed by: Clinic or ward.
Instructions: Put an "X" beside the test that is needed. For tests not listed, write their names at the bottom of the list.
Remarks: On most forms, the correct box is marked "X."

Block: Results or Report.
Completed by: Laboratory.
Instructions: Write or stamp the results of each test performed.
Remarks: N/A

Table 8-2
Specific instructions for preparing laboratory forms

Form: SF 545
Use: To mount laboratory forms.
Remarks: Instructions for mounting laboratory forms are printed on the bottom of SF 545. When a patient needs the same type of test several times, use the same display sheet for each test result form. When only a few tests are made, mount the forms on alternate strips (that is, 1, 3, 5, and 7). When there is a mixed assortment of forms, mount them in the most practical sequence. After mounting the forms, check the proper boxes in the lower right corner to show which forms are displayed.

Form: SF 546
Use: To request blood chemistry tests.
Remarks: At the bottom of the list of tests, there is a block requesting a battery or profile of tests. When requesting this battery, enter the name of the profile.

Form: SF 547
Use: To request blood gas measurements, T3, T4, serum iron, iron-binding capacity, glucose tolerance, and other chemistry tests.
Remarks: N/A

Form: SF 548
Use: To request chemistry tests on urine specimens.
Remarks: Explain a check in the "Other" box under "Specimen Interval."

Form: SF 549
Use: To request routine hematology (including differential morphology), coagulation measurements, and other hematology tests.
Remarks: N/A

Form: SF 550
Use: To request urinalysis tests, both routine and microscopic.
Remarks: Use "HCG" to request and report measurements of human chorionic gonadotropin. Use "PSP" to request and report phenolsulfonphthalein measurements.

Form: SF 551
Use: To request tests that measure serum antibodies, including tests for syphilis.
Remarks: Definitions for the serology test abbreviations are as follows:
RPR--rapid plasma reagin card test for syphilis.
COLD AGG--cold agglutinins.
ASO--antistreptolysis 0 titers.
CRP--C-reactive protein.
FTA-ABS--fluorescent treponemal antibody-absorption test.
FEBRILE AGG--febrile agglutinins.

COMP FIX--complement fixation.
HAI--hemagglutination-inhibition.
TPHA--treponema pallidum hemagglutination.
Write the name of the specific antibody determination in the COMP FIX or HAI block.

Form: SF 552
Use: To request tests for intestinal parasites, malaria, and other blood parasites, and most feces tests.
Remarks: N/A

Form: SF 553
Use: To request most bacteriological isolations and sensitivities.
Remarks: See table 8-1 (Specimen Source block) for information on preparing the Infection, Clinical Information, and Antibacterial Therapy blocks.

Form: SF 554
Use: To request tests for fungi, acid-fast bacteria (tuberculosis), and viruses.
Remarks: See table 8-1 (Specimen Source block) for information on preparing the Infection, Clinical Information, and Antibacterial Therapy blocks.

Form: SF 555
Use: To request spinal fluid tests.
Remarks: To request bacteriological studies on spinal fluid specimens, submit SF 553 or SF 554 also. Bacteriological cultures must grow at least 24 hours before the results can be observed. The extra request form allows complete identification of the specimen; it also allows the quick return of the cell count and chemistry results to the physician without a wait for the bacteriological results. When requesting electrophoresis measurements, also submit SF 557. These measurements take many hours to complete, and the report is a tracing by a densitometer on special paper. The extra request form allows complete identification of the specimen; it also allows the cell count and chemistry results to be returned quickly to the physician without a wait for the electrophoresis results to be completed.

Form: SF 556
Use: To request blood grouping, blood typing, and blood bank tests.
Remarks: Do not use this form as a request for blood crossmatching; such requests are made on SF 518. Specimen source information is needed for obstetric patients.

Form: SF 557
Use: To request tests, such as electrophoresis and assays of coagulation factors, which are not ordered on other forms.
Remarks: N/A

All forms should be filed in an upright position on both sides of the folder.

LEFT SIDE OF FOLDER

DA Form 5571[1]
Master Problem List. Filing in ITR is optional. (See para 5-10.)

DA Form 3947
Medical Evaluation Board Proceedings. (See AR 40-3 and para 5-19a(5) of this regulation.)

DA Form 3349
Physical Profile. (See AR 40-501 and para 5-19b(3) of this regulation.)

DA Form 3894
Hospital Report of Death. Use to meet the requirements of STANAG 2046. (See AR 40-2 and para 3-13 of this regulation.)

DA Form 2631-R
Medical Care--Third Party Liability Notification. (See chap 14.)

DD Form 2569
Third Party Collection Program--Insurance Information.

DA Form 2984
Very Seriously Ill/Seriously Ill/Special Category Patient Report. (See AR 40-2.)

DA Form 4876-R[1]
Request and Release of Medical Information to Communications Media. (See para 2-3.)

DA Form 5006-R[1]
Medical Record--Authorization for Disclosure of Information. File here any other authorization for release of medical information and related correspondence. (See para 2-3.)

DA Form 5009-R[1]
Medical Record--Release Against Medical Advice. (See para 8-21.)

Administrative documents and other correspondence, including advance directives (durable powers of attorney for health care, living wills, etc.). (See para 8-2.)

DA Form 5303-R
Volunteer Agreement Affidavit. (See AR 40-38 and para 6-2h of this regulation.)

RIGHT SIDE OF FOLDER

DA Form 4515
Personnel Reliability Program Record Identifier. Use when patient is participating in the Personnel Reliability Program. (See AR 50-5 or AR 50-6 and paras 5-19b(8) and 5-29c of this regulation.)
DA Form 3647
Inpatient Treatment Record Cover Sheet or CHCS automated cover sheet. All versions. (See AR 40-400 and paras 3-12a(1), 3-13b, 3-17a, 3-18b, 5-2a, 5-19a, 6-7, 8-7b, 8-12, 8-13, 8-14, 8-15, 8-16, and 9-2 of this regulation.)

DA Form 3647-1
Inpatient Treatment Record Cover Sheet (For Plate Imprinting). (See AR 40-400.)

SF 502[1]
Clinical Record--Narrative Summary. (See para 8-10.)

SF 503[1]
Clinical Record--Autopsy Protocol. Used as a summary for detailed autopsy reports. (See para 8-10f.)

DD 539[1]
Medical Record--Abbreviated Medical Record. (See para 8-17.)

SF 504[1]
Clinical Record--History--Part I. (See para 8-10.)

SF 505[1]
Clinical Record--History--Parts II and III. (See para 8-10.)

SF 506[1]
Clinical Record--Physical Examination. (See para 8-10.)

SF 535[1]
Clinical Record--Newborn. Civilian source pediatric growth charts. (See para 6-2d.)

DA Form 5694[1]
Denver Developmental Screening Test. (See para 6-2e of this regulation.)

SF 507[1]
Clinical Record--Report on or Continuation of SF. File with the standard form being continued. (See para 8-10.)

SF 509[1]; SF 558[1]

Medical Record--Progress Notes; Medical Record--Emergency Care Treatment. (See paras 5-14 and 8-10.)

DA Form 3888
Nursing Assessment and Care Plan. (See paras 3-3 and 8-X.)

DA Form 3888-2
Medical Record--Nursing Care Plan. (See para 8-X.)

DA Form 3888-3
Medical Record--Nursing Discharge Summary. (See para 8-X.)

SF 510
Clinical Record--Nursing Notes (formerly DD Form 640 and DA Form 4336). (See paras 3-2, 8-10, 8-11, and 8-X.)

DA Form 5179
Medical Record--Preoperative/Postoperative Nursing Document. (See para 8-X.)

DA Form 5179-1
Medical Record--Intraoperative Document. (See para 8-X.)

DA Form 3950
Flowsheet for Vital Signs and Other Parameters. (See para 8-X.)

SF 511[1]
Medical Record--Vital Signs Record (formerly Temperature-Pulse-Respiration (Fahrenheit)).

SF 512[1]
Clinical Record--Plotting Chart. (See para 5-13.)

SF 513[1]; DD Form 2161
Medical Record--Consultation Sheet; Referral for Civilian medical Care. (See para 8-10.)

SF 545
Laboratory Report Display. File with SF 546, SF 547, SF 548, SF 549, SF 550, SF 551, SF 552, SF 553, SF 554, SF 555, SF 556, and SF 557 mounted. (See para 8-18.) Instructions for completing these forms are provided in tables 8-1 and 8-2.

SF 515[1]
Medical Record--Tissue Examination. (See paras 5-2 and 5-19.)

Armed Forces Institute of Pathology Consultation Report on Contributor Material

SF 516[1]
Medical Record--Operation Report. (See para 8-10.)

OF 517[1]
Clinical Record--Anesthesia. (See para 8-10.)

SF 518[1]
Medical Record--Blood or Blood Component Transfusion.

SF 519[1]; 519A[1]
Medical Record--Radiographic Reports. (See para 8-20.) SF 519 and SF 519A are obsolete; use for file purposes only.

SF 519-B[1]
Radiologic Consultation Request/Report. (See para 8-20.)

OF 520[1]
Clinical Record--Electrocardiographic Record (or CAPOC tracings).

OF 522[1] or State mandated forms
Medical Record--Request for Administration of Anesthesia and for Performance of Operations and Other Procedures. (See para 3-3.)

SF 523[1]
Clinical Record--Authorization for Autopsy.

SF 523A[1]
Medical Record--Disposition of Body.

OF 523-B[1]
Medical Record--Authorization for Tissue Donation.

SF 524[1]
Medical Record--Radiation Therapy.

SF 525[1]
Medical Record--Radiation Therapy Summary.

SF 526[1]
Medical Record--Interstitial/Intercavitary Therapy (formerly Radium Therapy).

SF 527[1]
Group Muscle Strength, Joint R.O.M. Girth and Length Measurements.

SF 528[1]
Clinical Record--Muscle and/or Nerve Evaluation--Manual and Electrical: Upper Extremity.

SF 529[1]
Medical Record--Muscle Function by Nerve Distribution: Trunk and Lower Extremity.

SF 530[1]
Clinical Record--Neurological Examination.

SF 531[1]
Medical Record--Anatomical Figure.

SF 533[1]
Medical Record--Prenatal and Pregnancy. Also file related prenatal documents. (See para 6-7h.)

SF 534[1]
Medical Record--Labor.

SF 536[1]
Clinical Record--Pediatric Nursing Notes.

SF 537[1]
Medical Record--Pediatric Graphic Chart.

SF 538[1]
Clinical Record--Pediatric.

SF 541[1]
Medical Record--Gynecological Cytology (formerly Cytology Examination).

SF 560[1]
Medical Record--Electroencephalogram Request and History (formerly DA Form 4530). SF 560 is obsolete; use for file purposes only.

DA Form 3824[1]
Urologic Examination.

DA Form 4221[1]
Diabetic Record.

DA Form 4256
Doctors Orders. (See para 8-19 for completion instructions.)

DA Form 4677
Therapeutic Documentation Care Plan (Non-Medications). (See paras 8-X and 8-19.)

DA Form 4678
Therapeutic Documentation Care Plan (Medication). (See paras 8-X and 8-19.)

DA Form 4530
Electroencephalogram Request and History. (See SF 560.) DA Form 4530 is obsolete; use for file purposes only.

DA Form 4700[1]
Medical Record--Supplemental Medical Data. (See chap 3.)

DA Form 5128[1]
Clinical Record--Visual Field Examination (formerly DD Form 742).

DD Form 602
Patient Evacuation Tag. Staple to SF 502. (See AR 40-40/AFR 164-3/BUMEDINST 4650.2A and para 8-4 of this regulation.)

DD Form 741[1]
Eye Consultation.

DD Form 742
Clinical Record--Visual Field Examination. (See DA Form 5128.) DD Form 742 is obsolete; use for file purposes only.

DD Form 749
Clinical Record--Head Injury. DD Form 749 is obsolete; use for file purposes only.

DD Form 1380
U.S. Field Medical Card. (See chap 9 for completion instructions.)

DA Form 4359-R
Authorization for Psychiatric Service Treatment. (See AR 40-3.)

Medical reports (for example, autopsy report and fetal death certificate) on a stillborn infant. File in the mother's ITR.

DA Form 2985
Admission and Coding Information. (See AR 40-400 and para 3-18 of this regulation.)

DA Form 4410-R

Disclosure Accounting Record. DA Form 4410-R is preprinted on inside of record folder. The separate DA Form 4410 is obsolete; use for file purposes only.

DD Form 2005
Privacy Act Statement--Health Care Records. To be included when preprinted DA Form 3444-series folders are not used. (See AR 40-2 and para 4-4 of this regulation.)

1 Instructions for completing this form are self-explanatory.

Example 1

The personnel needed for the patient undergoing myringotomy with tube insertion taking 45 minutes: There is one OR nursing team and one anesthesia provider. The case equals one episode of OR nursing and one episode of anesthesia.

Example 2

The personnel needed for a patient undergoing a cholecystectomy with intraoperative cholangiogram taking 4 hours: There is one OR nursing team and one additional circulator who is used for 1 hour and there is one anesthesia provider. The case equals 2.5 episodes of OR nursing and two episodes of anesthesia.

Example 3

The personnel needed for the patient undergoing an exploratory laporotomy for repair of a ruptured abdominal aneurysm taking 10 hours: For 3 hours there is one OR nursing team plus an additional scrub and two additional circulators, for the next 4 hours, there is one OR nursing team and two additional circulators, for the last 3 hours there is one OR nursing team, there are two anesthesia providers for the first 6 hours of the case, and for the next 4 hours there is one anesthesia provider. The case equals seven and one-half OR nursing episodes and six episodes of anesthesia; there is one anesthesia provider.